1185

Scale for the Assessment of Negative Symptoms SANS

PID# | | | | | |

RPN# H | 2 | 4 | 2 | 9 | 2

Site: 2 1 0 0 0 2

Interviewer: | |

Date | | / | | / | | | | |

Was form completed? ○ Yes ○ No

AFFECTIVE FLATTENING OR BLUNTING

Affective flattening or blunting manifests itself as a characteristic impoverishment of emotional expression, reactivity, and feeling. Affective flattening can be evaluated by observation of the paient's behavior and responsiveness during a routine interview. The rating of some items may be affected by drugs, since the Parkinsonian side-effects of phenothiazines may lead to mask-like faces and diminished associated movements. Other aspects of affect, such as responsivity or appropriateness, will not be affected, however.

1. Unchanging Facial Expression

The patient's face appears wooden, mechanical, frozen. It does not change expression, or changes less than normally expected, as the emotional content of discourse changes. Since phenothiazines may partially mimic this effect, the interviewer should be careful to note whether or not the patient is on medication, but should not try to "correct" his/her rating accordingly. Additionally, many patients may have initial anxiety about being interviewed and may therefore act in a "formal" manner during the beginning of the interview. Therefore, when rating facial expression, more emphasis should be given to the subject's facial expressiveness after he/she has had a chance to "warm up" to the interview. For subjects who still have decreased facial expressiveness after an appropriate "warm up" period, the interviewer should prompt the subject by smiling or telling a joke to see if the patient responds.

○ Not at all. Patient is normal or labile.

○ Questionable decrease.

○ Mild. Slight decrease in the range of facial expression during the interview.

○ Moderate. Range of facial expression is definitely restricted but there is some spontaneous expressiveness during the interview.

○ Marked. Facial expression is wooden and/or unchanging except in response to prompting.

○ Severe. Facial expression is wooden throughout the entire interview even when prompted.

2. Decreased Spontaneous Movements

The patient shows few or no spontaneous movements, does not shift position, move extremities, etc.

○ Not at all. Patient moves normally or is overactive.

○ Questionable decrease.

○ Mild. Some decrease in spontaneous movements.

○ Moderate. Significant decrease in spontaneous movements.

○ Marked. Movements are markedly decreased.

○ Severe. Patient sits immobile throughout the interview.

3. Paucity of Expressive Gestures

The patient does not use his/her body as an aid in expressing his/her ideas through such means as hand gestures, sitting forward in his/her chair when intent on a subject, leaning back when relaxed, etc. This may occur in addition to decreased spontaneous movements.

- ⬭ Not at all. Patient uses expressive gestures normally or excessively.
- ⬭ Questionable decrease.
- ⬭ Mild. Uses expressive gestures but is less animated than appropriate for interview situation.
- ⬭ Moderate. Uses expressive gestures sometimes but is noticeably less animated than appropriate for the interview situation.
- ⬭ Marked. Patient very infrequently uses his/her body as an aid in expression.
- ⬭ Severe. Patient never uses his/her body as an aid in expression.

4. Poor Eye Contact

When speaking or listening, the patient avoids looking at the interviewer. He/she does not use eye contact to facilitate communication with the interviewer. Do not rate for periods when the patient looks away to compose his/her thoughts.

- ⬭ Not at all. Good eye contact and expression.
- ⬭ Questionable decrease.
- ⬭ Mild. When speaking or listening, the patient overall maintains eye contact with the interviewer but does look away during the interview for brief periods of time.
- ⬭ Moderate. Patient fails to make eye contact with the interviewer to the extent that communication between the patient and interviewer seems reduced.
- ⬭ Marked. Patient does not make eye contact with the interviewer for most of the interview.
- ⬭ Severe. Patient orients himself/herself away from the interviewer for most or all of the interview.

5. Affective Non-Responsivity

The patient fails to smile or laugh when prompted.

- ⬭ Not at all.
- ⬭ Questionable lack of responsivity.
- ⬭ Mild. Slight but definite lack in responsivity.
- ⬭ Moderate. Moderate decrease in responsivity.
- ⬭ Marked. Marked decrease in responsivity.
- ⬭ Severe. Patient essentially unresponsive, even on prompting.

6. Lack of Vocal Inflections

While speaking the patient fails to show normal vocal emphasis patterns. Speech has a monotonous quality, and important words are not emphasized through changes in pitch or volume. Patient also may fail to change volume with changes of subject so that he does not drop his voice when discussing private topics or raise it as he discusses things which are exciting or for which louder speech might be appropriate.

- ⬭ Not at all. Normal vocal inflections.
- ⬭ Questionable decrease.
- ⬭ Mild. Slight decrease in range of vocal inflections.
- ⬭ Moderate. Definite decrease in range of vocal inflections although subject has some spontaneous change in inflection.
- ⬭ Marked. Most of speech during interview is in a monotone.
- ⬭ Severe. Virtually all speech during interview is in a monotone.

7. Global Rating of Affective Flattening

The global rating should focus on overall severity of affective flattening or blunting. Special emphasis should be given to such core features as lack of expression and overall decrease in emotional intensity.

- ⬭ No flattening. Normal affect.
- ⬭ Questionable affective flattening.
- ⬭ Mild affective flattening.
- ⬭ Moderate affective flattening.
- ⬭ Marked affective flattening.
- ⬭ Severe affective flattening.

ALOGIA

Alogia is a general term coined to refer to the impoverished thinking and cognition that often occur in patients with schizophrenia (Greek a = no, non; logos = mind, thought). Patients with alogia have thinking processes that seem empty, turgid, or slow. Since thinking cannot be observed directly, it is inferred from the patient's speech. The two major manifestations of alogia are nonfluent empty speech (poverty of speech) and fluent empty speech (poverty of content of speech). Blocking and increased latency of response may also reflect alogia.

8. Poverty of Speech

Restriction in the amount of spontaneous speech, so that replies to questions tend to be brief, concrete, and unelaborated. Unprompted additional information is rarely provided. For example, in answer to the question, "How many children do you have", the patient replies, "Two. A girl and a boy. The girl is 13 and the boy is 10." "Two" is all that is required to answer the question, and the rest of the reply is additional information. Replies may be monosyllabic, and some of the questions may be left unanswered altogether. When confronted with this speech pattern, the interviewer may find himself/herself frequently prompting the patient in order to encourage elaboration of replies. To elicit this finding, the examiner must allow the patient adequate time to answer and to elaborate his answer.

- ⬭ No poverty of speech. A substantial and appropriate number of replies to questions include additional infromation.
- ⬭ Questionable poverty of speech.
- ⬭ Slight poverty of speech. Occasional replies do not include elaborated information even though this is appropriate.
- ⬭ Moderate poverty of speech. Some replies do not include appropriately elaborated information, and many replies are monosyllabic or very brief ("Yes." "No." "Maybe." "Don't know." "Last week.").
- ⬭ Marked poverty of speech. Answers are rarely more than a few words in length.
- ⬭ Severe poverty of speech. Patient says very little and occasionally fails to answer questions.

9. Poverty of content of Speech

Although the subject's replies are long enough, they convey little information. Speech may be nebulous, overabstract, overconcrete or repetitive. The interviewer may find that the patient has spoken at some length but has not given adequate information to answer the question. Alternatively, the patient may provide enough information, but require many words to do so, so that a lengthy reply can be summarized in a sentence or two. Sometimes the interviewer may characterize the speech as "empty philosophizing."

Exclusions: This finding differs from circumstantiality in that the circumstantial patient tends to provide a wealth of detail.

- ⬭ No poverty of content of speech.
- ⬭ Questionable poverty of content of speech.
- ⬭ Mild poverty of content of speech. Occasional replies are too vague to be comprehensible or can be markedly condensed.
- ⬭ Moderate poverty of content of speech. Replies which are vague or can be markedly condensed make up at least a quarter of the interview.
- ⬭ Marked poverty of content of speech. At least half of the patient's speech is composed of vague or incomprehensible replies.
- ⬭ Severe poverty of content of speech. Nearly all the patient's speech is vague, incomprehensible, or can be markedly condensed.

10. Blocking

Interruption of a train of speech before a thought or idea has completed. After a period of silence which may last from a few seconds to minutes, the person indicates that he/she cannot recall what he had been saying or meant to say. **Blocking should only be judged to be present if a person voluntarily describes losing his/her thought or if upon questioning by the interviewer the person indicates that that was his/her reason for pausing.**

- ⬭ No blocking.
- ⬭ Questionable decrease.
- ⬭ Mild blocking. A single instance noted during a 15 minute period.
- ⬭ Moderate blocking. Occurs twice during 15 minutes.
- ⬭ Marked blocking. Occurs three times during 15 minutes.
- ⬭ Severe blocking. Occurs more than three times.

11. Increased Latency of Response

The patient takes a longer time to reply to questions than is usually considered normal. He/she may seem "distant" and sometimes the examiner may wonder if he/she has even heard the question. Upon questioning by the interviewer, the patient should indicate that he/she is aware of the question but is having difficulty in developing his/her thoughts.

- ⬭ Not at all. Patient typically replies promptly.
- ⬭ Questionable increase.
- ⬭ Mild. Occasional brief pauses before replying.
- ⬭ Moderate. Frequent brief pauses before replying.
- ⬭ Marked. Long pauses before replying to half of questions.
- ⬭ Severe. Long pauses prior to nearly all replies.

12. Global Rating of Alogia

Since the core features of alogia are poverty of speech and poverty of content, the global rating should place particular emphasis on these.

- ○ No alogia.
- ○ Questionable alogia.
- ○ Mild. Mild but definite impoverishment in thinking.
- ○ Moderate. Significant evidence for impoverished thinking.
- ○ Marked. Patient's thinking seems impoverished much of the time.
- ○ Severe. Patient's thinking seems impoverished nearly all the time.

AVOLITION-APATHY

Avolition manifests itself as a characteristic lack of energy, drive and interest. Patients are unable to mobilize themselves to initiate or persist in completing many different kinds of tasks. Unlike the diminished energy or interest of depression, the avolitional symptom complex in schizophrenia is usually not accompanied by saddened or depressed affect.

13. Grooming and Hygiene

The patient displays less attention to grooming and hygiene than normal. Clothing may appear sloppy, outdated, or soiled. The patient may bathe infrequently and not care for hair, nails, or teeth, leading to such manifestations as greasy or uncombed hair, dirty hands, body odor, or unclean teeth and bad breath. Overall, the appearance is dilapidated and disheveled. In extreme cases, the patient may even have poor toilet habits with soiling.

- ○ No evidence of poor grooming and hygiene.
- ○ Questionable decrease.
- ○ Mild. Some slight but definite indication of inattention to appearance (e.g. hair not combed, rumpled clothing).
- ○ Moderate. Appearance is somewhat disheveled (e.g. as above but more severe or clothes inappropriate or mismatched).
- ○ Marked. Appearance is significantly disheveled (e.g. bathes infrequently, clothes soiled).
- ○ Severe. Appearance is extremely disheveled (e.g. refused to bathe, clothes filthy, unfastened, or refuses to wear clothes).

ROLE FUNCTION

The patient may have difficulty fulfilling social role expectations (employment, school, homemaking) as appropriate for his or her age and cultural background.

In rating role functioning, one must consider both 1) the difficulty of the role that the patient is attempting to fulfill and 2) how well the patient is functioning within that role. Therefore, this item is rated in two parts. First, the degree to which the patient's current role is appropriate to his/her age and social and cultural background is rated. Next, the degree to which the patient fulfills that role is rated separately.

14. Current Role Function - Level

Patient's current social/vocational level (code "Low-expectation psychiatric setting" for inpatients)

- ○ Age and socially appropriate role (full-time paid employment, matriculated in full-time school program NOT including psychiatric rehabilitation affiliated work or school programs, fulfills expectations of full-time homemaker, etc.).
- ○ Questionable decrease.
- ○ As above not full-time (part-time student, part-time paid employment, etc.)
- ○ High-level psychiatric setting (high-level day program, vocational programs, etc.)
- ○ Low-expectation psychiatric setting (e.g. social/recreational programs or undemanding training programs).
- ○ Does not engage in any appropriate activities (no job, training program or therapeutic program) or is an inpatient.

15a. Current Role Function -Quality - For Outpatients Only

Degree to which patient fulfills role noted above in item # 14.

- ○ Fulfills expectations of current role (as rated in previous item).
- ○ Questionable decrease.
- ○ Fulfills expectations of current role but with some difficulty (e.g. occasionally misses work, school or program without justifiable reason, occasionally fails to fulfill responsibilities.
- ○ Has definite difficulty fulfilling role responsibilities (e.g. consistently fails to attend and/or participate appropriately in current role.
- ○ Functioning at current role is seriously compromised and/or in danger of being dropped from current activity.
- ○ Not functioning in role **(Note: Patients given this rating should have been rated "Low-expectation psychiatric setting" on item 14.)**

15b. Participation in Unit - Appropriate Activities - For Inpatients Only

Patients may have difficulty in attending and/or participating in assigned activities and general unit activities such as groups on the unit. Patients with mild impairment may attend activities but do not participate fully or do not complete assigned tasks. Patients with more severe impariment attend activities only with staff encouragement or not at all.

- ○ Participates appropriately in unit activities.
- ○ Questionable decrement in participation.
- ○ Mild. Patient requires some encouragement to attend or maintain participation in activities.
- ○ Moderate. Patient attends most activities but needs frequent prodding to attend or maintain participation.
- ○ Marked. Patient attends activities less than half the time and/or participated minimally.
- ○ Severe. Patient consistently fails to attend activities.

16. Physical Anergia

The core concept is the extent to which the patient tends to be physically inactive given age-appropriate expectations of the general population. He/she may spend large amounts of time in physically inactive and mentally undemanding tasks such as watching TV. The family may report that he/she spends most of his/her time "doing nothing except sitting around." The patient may report an increased need to rest beyond that appropriate for his/her level of physical exertion. In severe cases, he/she may spend most or all of his/her time in bed.

- ○ No evidence of physical anergia.
- ○ Questionable physical anergia.
- ○ Mild anergia. Spends slightly more time resting or in physically undemanding activities than expected given the patient's age.
- ○ Moderate anergia. Spends a significant amount of time resting or in physically undemanding tasks.
- ○ Marked anergia. Spends most of his/her time resting or in physically undemanding tasks.
- ○ Severe anergia. Spends almost all of his/her time resting or in physically undemanding tasks.

17. Global Rating of Avolition

The global rating should reflect the overall severity of the avolition symptoms, given expectations of outpatients.

- ⬭ No avolition.
- ⬭ Questionable avolition.
- ⬭ Mild but definitely present.
- ⬭ Moderate avolition.
- ⬭ Marked avolition.
- ⬭ Severe avolition.

ASOCIALITY - ANHEDONIA

18. Asociality

The core features of asociality is a decrease in social interactions with others. Rate primarily on the basis of patient report. Patients with mild asociality may not initiate social contact with others but do respond to overtures by others. In more severe cases, patients avoid social contact with others.

- ⬭ No evidence of lack of sociability.
- ⬭ Questionable decrease.
- ⬭ Mild. Reports some difficulty initiating social interactions but usually welcomes overtures by others.
- ⬭ Moderate. Rarely initiates social activities but sometimes responds to overtures by others.
- ⬭ Marked. Rarely initiates social activities; avoids being with others unless prodded by others.
- ⬭ Severe. Avoids being with others whenever possible.

19. Anhedonia

Patients with anhedonia have loss of interest in initiating pleasurable activities or, in more severe cases, lose the ability to experience pleasure when participating in activities normally considered pleasurable. Psychiatric patients frequently have significant financial restraints on the recreational activities in which they may engage. These restrictions should be taken into account in rating anhedonia.

- ⬭ No evidence of anhedonia; seeks out pleasurable opportunities available to him/her and reports enjoyment of activities he/she engages in.
- ⬭ Questionable decrease.
- ⬭ Mild. Does not usually initiate pleasurable activities but often participates in what is offered and enjoys it.
- ⬭ Moderate. Has to be encouraged to participate in pleasurable activities and/or sometimes does not enjoy otherwise pleasurable activities.
- ⬭ Marked. Usually does not participate in activities and reports little enjoyment or activities.
- ⬭ Severe. Reports total inability to enjoy activities.

20. Decreased Sexual Interest and Activity

The patient may show a decrement in sexual interest and/or activity. Rate upon the basis of expressed interest and activities engaged by patient given the patient's environment and social and cultural background.

- ⬭ No evidence of decreased sexual interest or activity.
- ⬭ Questionable decrease.
- ⬭ Mild. Reports some diminished interest in sex but does pursue some sexual activity.
- ⬭ Moderate. Expresses interest in sex but little or no pursuit of sexual activity.
- ⬭ Marked. Reports little interest in sex and does not pursue sexual activity.
- ⬭ Severe. Reports no interest in sex and no sexual activity.

21. Ability to Feel Intimacy and Closeness

The patient may be unable to form close and emotionally intimate relationships. The core feature to be rated is the degree to which patients can confide with others their feelings, goals, problems, or other important aspects of their lives. This should be distinguished from patients who may be superficially sociable without being close to others.

- ⬭ Consistently maintains a close relationship with at least one family member/spouse and at least one person outside family.
- ⬭ Questionable decrease.
- ⬭ Mild. Consistently maintains a close relationship with either a family member or one person outside the family.
- ⬭ Moderate. Sometimes is able to be close to a family member or someone outside the family.
- ⬭ Marked. Rarely is able to be close to others.
- ⬭ Severe. Has no close relationships with family or people outside the family.

22. Global Rating of Asociality - Anhedonia

The global rating should reflect the overall severity of the asocial-anhedonic symptoms.

- ⬭ No asociality-anhedonia.
- ⬭ Questionable asociality-anhedonia.
- ⬭ Mild asociality-anhedonia.
- ⬭ Moderate asociality-anhedonia.
- ⬭ Marked asociality-anhedonia.
- ⬭ Severe asociality-anhedonia.